A BETTER LIFE CHIROPRACTIC

Dr. Deanna Barbaro D.C.
Chiropractor
661 Goodlette Road North. Ste 108 - Naples, FL 34102
Tel: (239)263-3369 Fax: (239) 263-8842

Welcome to our practice! Protected Health Information - Please complete in full. Thank you!

Name: ____ Date: _____________ SS# _________________

Date of Birth: _____/______/_______ Age: _______ Sex: M F Marital Status: M W D S

Home #: ____________________Cell #: ____________________ E-Mail Address: ______________________________

How were you referred to our office? ____

☐ **Full Time Resident** ☐ **Seasonal Resident** ☐ **Temporary Visitor, Leaving when?** ________________

Local Address: ____ City: ___________________ Zip: ____________

Permanent Address: _________________________________ City, State: ________________________ Zip: ________

Employer: ____ Occupation: ____________________________

Who is financially responsible for this bill? ____

Method of Payment: (circle one) Cash Check Credit Card Insurance

List your chief complaints:

____

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No If Yes, when? ____________________

What do you hope to achieve with Chiropractic care? ☐Relief of symptoms only ☐ Total Corrective Care

All first visit charges are payable when services are rendered.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand A BETTER LIFE CHIROPRACTIC will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to A BETTER LIFE CHIROPRACTIC will be certified upon receipt. HOWEVER, I clearly understand and agree that I am personally responsible for payment.

Interest in the amount of 18% per annual or 1.5% per month will be charged on your account if it becomes past due.

x____ ____________________

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN DATE

In case of emergency, Please notify: ____ ________________

Name/Relation Tel #

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I HAVE READ A COPY OF **PATIENT NOTICE OF PRIVACY PRACTICES**.

(A Copy of A BETTER LIFE CHIROPRACTIC Notice of Privacy Practices can be provided upon request)

x____ ____________________

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN **DATE**

HEALTH HISTORY

Check the following conditions that apply (past/present). Please add your comments to clarify the condition.

Musculo-Skeletal

__ Neck Pain
__ Mid Back Pain
__ Low Back Pain
__ Shoulder / Arm / Hand Pain
__ Headaches/ Migraines
__ Jaw Pain / TMJ
__ Chest / Rib Pain
__ Hip Pain
__ Sciatic Pain
__ Leg/foot pain
__ Broken/Fractured bones
__ Strains/Sprains
__ Tendonitis
__ Bursitis
__ Arthritis
__ Osteoporosis
__ Scoliosis
__ Bone or Joint Disease
__ Other: ___________________

Cardiovascular

__ High Blood Pressure
__ Low Blood Pressure
__ Stroke
__ Shortness of Breath at Night
__ Fainting
__ Cold Feet or Hands
__ Swollen Ankles/ Legs
__ Heart Condition: __________

Respiratory

__ Asthma
__ Shortness of Breath
__ Allergies
__ Sinus Problems
__ Other: ___________________

Digestive

__ Nervous Stomach
__ Heartburn/Indigestion
__ GERD
__ Intestinal Gas/Bleeding

Digestive (Cont'd)

__ Abdominal Pain
__ Constipation
__ Diarrhea
__ Diverticulitis
__ Irritable Bowel Syndrome
__ Crohn's Disease
__ Colitis
__ Ulcers
__ Other: ___________________

Nervous System

__ Dizziness
__ Numbness / Tingling
__ Twitching of Face
__ Fatigue
__ Paralysis
__ Unsteadiness of Gait
__ Epilepsy / Seizures
__ Bell's Palsy
__ Chronic Fatigue Syndrome
__ Multiple Sclerosis
__ Parkinson's Disease
__ Spinal Cord Injury
__ Other: ___________________

Skin

__ Rashes
__ Other: ___________________

Genitourinary

__ PMS
__ Menopause
__ Pelvic Inflammatory Disease
__ Endometriosis
__ Hysterectomy
__ Fertility Concerns
__ Prostate Concerns
__ Bladder Infection
__ **Pregnancy**:
____ Current _____ Previous
Date of Last Menstrual Cycle:
______/______/______

Endocrine

__ Diabetes
__ Hypo Thyroidism
__ Hyper Thyroidism
__ Low Blood Sugar
__ Other: ___________________

Psychological

__ Forgetfulness
__ Confusion
__ Difficulty Concentrating
__ Depression
__ Insomnia
__ Eating Disorder
__ Anxiety
__ Behavioral Changes

Hematology

__ Anemia
__ Blood Clotting
__ Bruise Easily
__ Fatigue
__ Lymph node Swelling

Other

__ Frequent Ear Infections
__ Drug Use ________________
__ Nicotine Use _____________
__ Hearing Impaired
__ Visually Impaired
__ Cancer
Type: ____________________
Date Diagnosed ___________

Infectious Disease (Confidential)

__ HIV __ TB __ Hepatitis

Other congenital or acquired disease(s):

____

Surgeries:____

Please list any additional comments regarding your health and well-being: _______________________________

____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Patient Signature: ________________________________ Date: ________________

Doctor **Signature**: ________________________________ Date: ________________

PATIENT NAME: ____ DATE: _________________________

***** RATE YOUR PAIN *****

Neck: (Scale 1-10) _________ Constant On/Off - Nature: Sharp Achy Dull Stiff Stabbing Burning

How Long?__________ Was there an event that caused it?_____________________________________

Radiates: ___________________________ Do you feel: Weakness Numbness Tingling

Onset: Sudden or Gradual?

Worse with: Sneezing/Coughing Activity Lying Resting Prolonged Position

Relieved by: Rest Activity Lying Sitting Standing Heat Ice Rx:________________________

Midback: (Scale 1-10) _________ Constant On/Off - Nature: Sharp Achy Dull Stiff Stabbing Burning

How Long?__________ Was there an event that caused it?_____________________________________

Radiates: ___________________________ Do you feel: Weakness Numbness Tingling

Onset: Sudden or Gradual?

Worse with: Sneezing/Coughing Activity Lying Resting Prolonged Position

Relieved by: Rest Activity Lying Sitting Standing Heat Ice Rx:________________________

Low Back (Scale 1-10) _________ Constant On/Off - Nature: Sharp Achy Dull Stiff Stabbing Burning

How Long?__________ Was there an event that caused it?_____________________________________

Radiates: ___________________________ Do you feel: Weakness Numbness Tingling

Onset: Sudden or Gradual?

Worse with: Sneezing/Coughing Activity Lying Resting Prolonged Position

Relieved by: Rest Activity Lying Sitting Standing Heat Ice Rx:________________________

** MEDICATIONS **

Please print your medications legibly below along with the dosage **or** provide us with a copy of your medication list for Dr. Barbaro to check for potential problems. This service is done for no charge for patients of A Better Life Chiropractic

Medication	Dosage	Medication	Dosage
________________________	__________	________________________	__________
________________________	__________	________________________	__________
________________________	__________	________________________	__________
________________________	__________	________________________	__________
________________________	__________	________________________	__________
________________________	__________	________________________	__________
________________________	__________	________________________	__________

MASSAGE THERAPY CLIENT WAIVER

I do hereby consent to having Massage Therapy performed by the therapists of A Better Life Chiropractic, Dr. Deanna Barbaro. I understand treatment may include *various massage techniques* involving movements of joints and soft tissues. I am aware that it is common to experience *muscle soreness* within the first few treatments. I do understand that underlying pathology, perhaps unknown to me or the therapist may render me more susceptible to injury. I further understand that **I will inform the therapist if any unusual physical discomfort occurs during or after treatment.**

I do understand that some of the therapy methods used in the office generate *heat*, such as hot stones, hot towels, hot shells and can rarely cause burn. **During treatment I will inform the therapist my level of temperature comfort to avoid burns.** I freely assume any risk on my chosen treatment.

Cancellation Policy: Massage Therapy is a separate entity within our office. A minimum of 24 hours advanced cancellation is required. If notification is not received within this time period, you will be responsible for a $45 cancellation fee. Full massage session fees will apply if you are late for your appointment. No future massage appointments will be scheduled if you have an outstanding bill. I understand the above stated massage cancellation policy by signing below.

Therapist Preferred: Female ________Male _________Either_________

Please initial below:

_______ I understand that massage therapy and bodywork are for the purposes of stress reduction, relief from muscular tension and spasm, general relaxation and improvement of circulation and energy flow.

______ I understand that the bodywork practitioner does not diagnose illness, disease or any other physical or mental disorder. The practitioner does not prescribe medical treatment or pharmaceuticals, nor does he/she perform any spinal manipulations. It has been made very clear that massage therapy and bodywork are not substitutes for medical examination or diagnosis and that it is recommended that I see a medical practitioner for any physical ailment that I may have.

______ I understand that services offered today, and in the future are not a substitute for medical care and that any information provided by the therapist is for educational purposes only and is not diagnostically prescriptive in nature.

______ I have stated all my known medical conditions on the Client Information Form. I have consulted a medical doctor or licensed medical health care practitioner regarding any checked or described conditions.

______ I realize it is solely my responsibility to keep the bodywork practitioner updated on any changes in my physical health and I understand that **A Better Life Chiropractic and Dr. Deanna Barbaro** shall not be liable should I fail to do so.

______ I understand that all massage therapy and bodywork offered is strictly non-sexual.

______ By signing this release, I hereby waive and release **A Better Life Chiropractic** and its staff, massage therapists and bodywork practitioners from any and all liability, past, present and future relating to massage therapy and bodywork.

Treatment Results:

I do understand there are beneficial effects associated with massage therapy including, but not limited to, decrease pain, improved mobility, reduced muscle spasm as well as relaxing effects. However, I do understand that massage therapy is not an exact science and I acknowledge that *no guarantee has been made to me regarding the outcome of this care.* Overall, I do agree with the treatment and am responsible for my decision to have massage therapy.

Print Name: ____ Date _____________

Client Signature ____

TERMS OF ACCEPTANCE

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those for findings, we will recommend that you seek the services of all health care providers who specializes in that area.

Chiropractic has only one goal. It is important that each patient understand both the *objective* and the *method* that will be used to attain it. This will prevent any confusion or disappointment. **Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. **Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential. Regardless of what a disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ___________________________ have read and fully understand the above statements and give my consent to be treated.

____ _____________

Signature Date

PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION [PHI]

I hereby give my consent for Dr. Deanna Barbaro of A Better Life Chiropractic to use and **(PHI)** about me to carry out **TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO).** I have the right to review the Notice of Privacy Practices prior to signing this consent. A Better Life Chiropractic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Deanna Barbaro, A Better Life Chiropractic, 661 Goodlette Road North, Suite 108; Naples, FL 34102 or send an email to office@ablchiro.com. With this consent, A Better Life Chiropractic **may call me, may email me, may mail, may text** my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

By signing this form, I am consenting to A Better Life Chiropractic's use and disclosure of (PHI) to carry out Treatment, Payment and Health care operations (TPO). I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, or later revoke it, A Better Life Chiropractic may decline to provide treatment to me.**

____ _________________________

Signature of Patient or Legal Guardian Date

INSURANCE PATIENTS

**** PLEASE NOTE ****

While our office makes every effort to obtain coverage information, unfortunately, we cannot guarantee that your insurance will pay benefits. This is due to the fact that insurance companies NEVER guarantee benefits until they review the file. This office does discount the PPO "contracted discounted amount" from the final payable patient portion. However, we are not responsible for disputed amounts which fall outside the contracted PPO allowed amount. Please realize it is the responsibility of each patient to contact his/her employer or benefits office for details of personal coverage. While we do make every effort to ensure your benefits, insurance coverage disputes are not the responsibility of our office. Insurance coverage is a contract between the patient and the insurance company. All charges incurred are the responsibility of the patient.

Please review your Explanation of Benefits received from insurance to review payment on services.

Signature: _______________________________ Date: _______________

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PLEASE FILL OUT THE HIGHLIGHTED AREAS ONLY

PICA PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

X Patient's Name (Last, First, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

X SIGNED ______________ X DATE ______________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

X SIGNED ______________

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.